U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 27 August 2003

CASE NO. 2002-BLA-96

In the Matter of

CAROL A. RAY Survivor of JAMES V. RAY,
Claimant

v.

ISLAND CREEK COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

James M. Phemister, Esquire
Ms. Michelle Rosenthal
Washington and Lee University Legal Clinic
For the Claimant

Mary Rich Maloy, Esquire
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER - DENYING BENEFITS

This proceeding arises from a claim for benefits filed by Carol A. Ray, the surviving spouse of James V. Ray, a now deceased coal miner, under the Black Lung Benefits Act, 30 U.S.C. §901, *et seq.* Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of

Federal Regulations.[1]

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease.

A formal hearing was held before the undersigned on December 12, 2002 in Charleston, West Virginia. At that time, all parties were afforded full opportunity to present evidence and argument as provided in the Act and the regulations issued. Furthermore, the record was held open to allow for the submission of additional evidence and post-hearing briefs. Pursuant to my rulings at the formal hearing (TR 28-37,43-53), and in Orders, dated January 28, 2003, February 12, 2003, and February 25, 2003, respectively, the documentary submissions received in evidence consists of Director's Exhibits 1 through 51, except for Director's Exhibit 49, which pertains to a different miner (DX 1-48,50-51), Claimant's Exhibits 1 through 10 (CX 1-10), and Employer's Exhibits 1-6,10,11,13, and 15 (EX 1-6,10,11,13, and 15). However, Employer's Exhibits 7,8,9,12, and 14 have been excluded. The record also includes the transcript of the December 12, 2002 hearing. Pursuant to my Order, dated April 22, 2003, I extended the time for the parties to submit closing argument to May 9, 2003. Accordingly, the closing arguments filed on behalf of Claimant and Employer, respectively, have been received and considered.

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[1] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The amended Part 718 regulations became effective on January 19, 2001 and were to apply to both pending and newly filed cases. The new Part 725 regulations also became effective on January 19, 2001. Some of the new procedural aspects of the Part 725 regulations, however, were to apply only to claims filed on or after January 19, 2001, *not* to pending cases. The Amendments to the Part 718 and 725 regulations were challenged in a lawsuit filed in the United States District Court for the District of Columbia in *National Mining Association v. Chao*, No. 1:00CV03086 (EGS). On February 9, 2001, the District Court issued a Preliminary Injunction Order which enjoined the application of the Amendments except where the adjudicator, after briefing by the parties to the pending claim, determines that the regulations at issue in the instant lawsuit will not affect the outcome of the case. On August 9, 2001, the United States District Court for the District of Columbia issued a decision granting the U.S. Department of Labor's motion for summary judgment in *National Mining Association v. Chao*, dissolved the Preliminary Injunction, and upheld the validity of the amended regulations. On appeal, the D.C. Circuit issued its decision in *National Mining Association, et al v. Dep't of Labor*, _____ F. 3d _____ (D.C. Cir. 14, 2002), which further addressed the validity and application of the revised regulations. With the exception of a few provisions, the Court affirmed the validity of the revised regulations, as well as its retroactive application. Furthermore, the provisions of revised 20 C.F.R. §718.205(c)(5) simply codifies existing law. Moreover, the Court expressly held that the "hastening death rule" set forth in §718.205(c)(5) is not arbitrary and capricious. Accordingly, under the facts herein, the Amendments do not affect the outcome of this claim.

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted, arguments made, and the testimony presented. Where pertinent, I have made credibility determinations concerning the evidence.

Procedural History

On or about September 8, 1983, James V. Ray, a former coal miner, filed an application for black lung benefits under the Act (DX 50-1). Following a formal hearing before Administrative Law Judge Eric Feirtag on October 25, 1989 (DX 50-65), he issued a Decision and Order denying benefits, dated December 15, 1989 (DX 50-56). In summary, Judge Feirtag found that the weight of the x-ray evidence did not support a finding of pneumoconiosis. Furthermore, Judge Feirtag stated:

> [N]o physician has diagnosed the existence of a disabling respiratory impairment arising out of coal mine employment. Likewise, the more recent pulmonary function studies and all of the blood gas studies contained in the record failed to yield results indicative of a disabling pulmonary impairment. Accordingly, the record does not provide a basis supporting the issuance of an award.

(DX 50-56).

Although the miner filed a Notice of Appeal on or about January 10, 1999 (DX 50-74), the Appeal was dismissed by the Benefits Review Board, because the miner failed to pursue it, as set forth in a memorandum to the Deputy Commissioner (now known as the District Director), dated February 11, 1991 (DX 50-77; DX 50-79; DX 50-81). Accordingly, the miner's claim is finally denied and administratively closed.

On September 6, 1999, James V. Ray passed away (DX 15). Shortly thereafter, on February 11, 2000, the Claimant, Carol A. Ray, filed the current application for black lung benefits under the Act, as his surviving spouse (DX 1). This claim was initially denied by the District Director's office on May 30, 2000, based upon its finding that the evidence did not show that the miner's pneumoconiosis caused his death (DX 18). However, on January 5, 2001, the District Director reversed the foregoing decision, and awarded benefits (DX 44). Following Employer's timely request for a formal hearing (DX 46), this matter was referred to the Office of Administrative Law Judges on February 5, 2002 for *de novo* adjudication (DX 51). I was assigned the case on August 2, 2002. As stated above, a formal hearing was held on December 12, 2002; and, the record was held open until May 9, 2003 for the submission of closing arguments.

Issues

Although the Employer initially listed almost every issue as contested on the Form CM-1025 transmittal sheet (DX 51), the issues were significantly narrowed at the formal hearing. In fact, Employer's counsel acknowledged that "the major issue remaining... is the cause of death" (TR 9-10). Similarly, Claimant's counsel stated: "the only contested issue is regarding the many years exposure of coal dust to which he was exposed and whether there was a substantial contribution or whether it substantially

contributed to or hastened his death." (TR 13).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background and Employment History

A. Coal Miner

Employer stipulated, and I find, that former miner, James V. Ray, engaged in coal mine employment for at least 25 years (TR 10), which is consistent with the District Director's finding (DX 44). The former miner had alleged "approx 33 yrs." of coal mine work (DX 50-1). Claimant testified that she thought her husband engaged in coal mine work from 1956 until November 1980 (TR 19-20). However, any discrepancy in the exact number of years of coal mine employment ranging from 25 to 33 years is inconsequential for the purpose of rendering a decision herein.

B. Date of Filing

Claimant, Carol A. Ray, filed her claim for survivor's benefits under the Act, on February 11, 2000 (DX 1). The Employer has stipulated, and I find, that the claim was timely filed (TR 9).

C. Responsible Operator

The named Employer, Island Creek Coal Company, has stipulated, and I find, that it is the properly designated responsible coal mine operator in this case, under Subpart F, Part 725 of the regulations (TR 10).

D. Dependents

Claimant, Carol A. Ray, has no dependents for purposes of augmentation of benefits under the Act (DX 1).

E. Personal Background and Other Lay Evidence

The former miner, James V. Ray, was born in May 1927.[2] He married Carol A. Ray (nee Barbe) on

[2] Mr. Ray listed his birth date as May 31, 1927 (DX 50-1), while Claimant stated that her husband was born on May 21, 1927 (DX 1). This slight discrepancy is insignificant. In his deposition testimony on June 10, 2002 (EX 3), Dr. Castle discussed the pertinent medical data Based upon his analysis, Dr. Castle reiterated that: the miner died of metastatic colon cancer which had metastasized to the lungs and possibly elsewhere; there is no evidence in the medical literature that coal worker's pneumoconiosis or coal dust exposure increases the risk of colon cancer or lung cancer; and, Mr. Ray's simple coal worker's pneumoconiosis did not cause, contribute, nor hasten the miner's death in any way (EX 3, pp. 24-25).

November 14, 1955. They remained married until the miner's death on September 6, 1999 (DX 1,14,15; DX 50-1; TR 24-25).

Claimant testified that her husband engaged in underground coal mine employment from 1956 until approximately November 1980 (TR 19-20). However, the former miner had previously testified, and I find, that he actually continued working as a coal miner until November 1982 (DX 50-65, pp. 8-9; *See also* DX 50-1). The miner's last coal mine job was as a mechanic and electrician. (DX 50-65, p. 10; DX 50-58). He worked in dusty conditions (TR 20-21).

The evidence regarding the miner's cigarette smoking history is somewhat conflicting. Mr. Ray had previously testified that he smoked between ½ pack per day and one pack per day beginning at age 18 and ending at age 40 (*i.e.*, 1945-1967)(DX 50-65, p. 19). In undated Answers to Interrogatories, which were mailed under cover letter dated January 6, 1989, the miner had stated that he started smoking "approximately 1947;" that he no longer smoked; that he used to smoke "less than one pack a day;" and, he quit smoking, or cut down, "approximately 15-20 years ago." (DX 50-58; Interrogatory 21). On the other hand, Claimant testified that her husband actually quit smoking in 1979, or, the first part of 1980 (TR 23). Moreover, Claimant testified that her husband "probably" quit smoking after he stopped working (TR 27). However, Claimant did not know whether her husband began smoking prior to their marriage (TR 26). Furthermore, she testified that her husband only smoked "about a half pack a day," and "probably," at times, less than that (TR 22-23). Taken as a whole, I find that Mr. Ray smoked approximately ½-1 pack per day beginning in the mid-1940's and ending in the early 1980's.

Medical Evidence

The case file includes various chest x-ray interpretations, pulmonary function studies, arterial blood gas tests, and medical opinions from the living miner's claim, which is part of the record (DX 50; *See also* DX 32[3]). Although there is medical evidence suggesting the presence of a mild respiratory or pulmonary impairment, taken as a whole, the evidence presented in the miner's case did not establish the existence of pneumoconiosis or total disability therefrom, as found by Judge Feirtag in his Decision and Order denying benefits, dated December 15, 1989 (DX 50-56). However, the Employer now concedes the presence of

[3] Director's Exhibit 32 includes a favorable opinion by the Social Security Administration, dated February 5, 1987. Although "restrictive lung disease" and "x-ray findings consistent with pneumoconiosis" are noted; the restrictive lung disease, as found on an August 16, 1985 pulmonary function study is described as "minimal." Furthermore, the May 1984 x-ray "consistent with pneumoconiosis" is contrary to the clear preponderance of the x-ray evidence in the early to mid 1980's (*See* DX 33; *Compare* DX 50-19,20,30,31,33,34,54,55). Moreover, I note that under the "Procedural History" section of the Social Security decision, it indicates that the miner filed for benefits on July 10, 1985, "contending that he has been unable to work since June, 1981, due to a heart condition, chest pain, weakness in his arms and swelling in his right leg (stemming from an earlier injury)." (DX 32). In any event, the conclusions reached by the Social Security Administration are not binding in this Federal black lung claim. In addition, Director's Exhibit 32 includes, in pertinent part, a report by Dr. R. Paul Bennett, dated September 7, 1990, which is discussed below (DX 32).

pneumoconiosis and its causal relationship to Mr. Ray's coal mine employment (TR 9-10). Furthermore, the nonqualifying results obtained on pulmonary function studies and arterial blood gas studies conducted ten or more years prior to the miner's death do not preclude the possibility that Mr. Ray's death, in 1999, was not caused or substantially related to pneumoconiosis. Moreover, the physicians opinions set forth in the miner's claim clearly do not address the "death due to pneumoconiosis" issue.

Since the crux of the survivor's claim is the "death due to pneumoconiosis" issue, I find that the most relevant medical evidence is as follows: the medical records regarding the miner's metastatic colon cancer and other records shortly before his death (DX 36); the miner's death certificate (DX 15); and, the medical opinions of Drs. Hansbarger (DX 17), Bennett (DX 16/40,42; CX 1,2,9), Naeye (DX 37; EX 4,5), Bush (DX 38; EX 11), Oesterling (DX 39; EX 6), Fino (DX 47; EX 5), Zaldivar (EX 1,3,6,10), Castle (EX 1,2, 5,13), Rosenberg (DX 48; EX 5), Cohen (CX 3,8,10), and Perper (CX 4,7; EX 15).

The Summersville Memorial Hospital records indicate that the miner was hospitalized from February 11, 1998 until his discharge on February 18, 1998 (DX 36). The operative report by Dr. Yancy Short, dated February 11, 1998, and the Discharge Summary, indicate that the miner underwent a colonoscopy to assess his rectal bleeding. In addition, Mr. Ray underwent a "low anterior resection with 31 mm EEA anastomosis" and "CT scan of chest, abdomen and pelvis." Based upon the foregoing, the following principal diagnoses were made: "1. Rectal carcinoma. 2. Probable metastatic lesions of the lung." (DX 36).

On March 10, 1998, Dr. J. Jay Baker, a medical oncologist, reported to Dr. Short "regarding his recent diagnosis of carcinoma of the colon," stating that the miner's "chest x-ray and CT scan appears to show pulmonary nodules consistent with metastatic disease although not diagnostic." (DX 36). Subsequently, on April 9, 1998, Dr. Baker stated, in pertinent part:

> ...Mr. James Ray...has adenocarcinoma of the rectum with positive nodes and now with documented metastatic disease to the lung. In view of this it is my feeling that the best approach to his treatment would be no treatment at this time. You have already treated his primary disease although he certainly has a good chance for recurrence. In view of his metastatic disease I wouldn't think that adjuvant treatment would be of benefit. He is totally asymptomatic at this time and that being the case anything I could offer him in the way of treatment would just given (sic) him side effects and no evidence of improvement. This is not a curable disease and therefore our treatment needs to be directed towards palliation. Consequently, I would like to withhold any treatment until there is some evidence that a response will offer the patient improved quality of life.

(DX 36).

Dr. Craig Coonley, a physician at Oncology/Hematology Associates in Clarksburg, West Virginia, issued a report, dated April 15, 1998, in which stated:

> I had the pleasure of seeing James Ray in initial consultation regarding his metastatic colon cancer on 4/15/98. As you know, he had rectal bleeding and a change in bowel habits in

> February and was found to have a State III carcinoma of the right colon that was resected by Dr. Short. Subsequently the patient had an evaluation of pulmonary nodules which were found to be malignant and consistent with metastatic colon cancer, indicating the patient does have Stage IV disease.
>
> I agree with Dr. Baker's assessment, that the patient has incurable disease. Presently he is asymptomatic. Early intervention with chemotherapy is unlikely to either make the patient feel much better or markedly improve his survival. I think we should monitor him for symptoms of his pulmonary metastases such as cough, dyspnea, hemoptysis, etc. and intervene at such time as these lesions produce symptoms. I explained this approach to the patient and his wife and they are in agreement. I will see him back again on 7/15/98 and I have ordered a baseline chest x-ray today. If there are any questions please do not hesitate to contact me. Thank you for allowing me to participate in the care of this delightful patient. I will keep you posted with regard to the results of his follow-up tests.

(DX 36).

In a supplemental report, dated July 15, 1998, Dr. Coonley advised Dr. Bennett, as follows:

> I had the pleasure of seeing James Ray for follow-up of his colon cancer and pulmonary nodules on 7/15/98. His chest x-ray when compared to the 4/15/98 study showed almost no significant change in the pulmonary nodules. The patient has no shortness of breath or hemoptysis and has actually gained several pounds since I saw him last. Overall he does not appear to have any need for palliative chemotherapy at this time. I will be seeing him back again in four months or sooner if necessary with a follow-up chest x-ray. If there are any questions. Please do not hesitate to contact me.

(DX 36).

The Summersville Memorial Hospital records establish that the miner underwent a colonoscopy to the cecum with biopsy of the anastomosis x2 on February 15, 1999. In the Report of Operation," Dr. Short set forth the following diagnoses: history of rectal cancer; status post low anterior resection with an EEA anastomosis; and, pulmonary metastasis (DX 36).

Dr. Craig Coonley issued an additional supplemental report, dated June 30, 1999, in which he advised Dr. Short of the following:

> I had the pleasure of seeing James Ray for follow-up of his metastatic colon cancer and pulmonary nodules on 6/30/99. He lost only 1 lbs. (sic) since I last saw him. His CEA is pending. He has no shortness of breath or cough. I did not get a chest x-ray today. He is starting to complain, however, of some constipation, whether this is from narcotics, narcotic analgesics or some growth of his local recurrence, it is hard to say. I did recommend that he start taking Colace and Senokot, that perhaps he should have another endoscopy to re-examine the sight of the anastomosis. The patient and the wife are aware

> that if he develops constructive symptoms of bleeding, he may be forced to subjecting him to a palliative surgical procedure. He could not have an MRI scan of the head due to some shrapnel in the eye. If there are any questions please do not hesitate to contact me.

(DX 36).

The miner's death certificate, which was signed by Dr. R. Paul Bennett, states that Mr. Ray died on September 6, 1999, at age 72. The immediate cause of death was reported as "Metastatic colon cancer." Under the heading - "Other significant conditions contributing to death but not resulting in the underlying cause given in Part I" - Dr. Bennett listed "Coal workers pneumoconiosis" (DX 15). The death certificate, in and of itself, is neither well-reasoned nor well-documented. Although it indicates that an autopsy was performed, it does not specify whether the autopsy findings were completed prior to completion of the cause of death section (DX 15). As discussed below, however, Dr. Bennett treated the miner for many years prior to the latter's death. My further discussion of Dr. Bennett's opinion and the weight to be accorded thereto is set forth below.

Dr. Echols A. Hansbarger, Jr., is the pathologist who performed the autopsy of the deceased miner on September 7, 1999 (DX 17). Dr. Hansbarger's autopsy report set forth his findings on external examination, internal examination, and a microscopic description. Based upon the foregoing, Dr. Hansbarger set forth the following final diagnoses:

1. Adenocarcinoma, Extensive, Of Lung Following Adenocarcinoma Of Colon;

2. Acute Bronchopneumonia;

3. Centrilobular Emphysema Of Lung, Mild.

4. Pulmonary Anthracosilicosis, Mild to Moderate (Coal Workers' Pneumoconiosis - Dust Reticulation Type);

5. Anthracosilicosis Of Bronchial Lymph Nodes;

6. Pulmonary Thrombi, Multiple;

7. Post Operative State; Remote Laparotomy;

8. Autopsy Limited To Lungs

(DX 17). In addition, Dr. Hansbarger set forth the following Final Note:

> This 72 year old male died as a result of metastatic adenocarcinoma of the colon with metastasis to the lungs. Extensive tumor deposits are noted throughout the lung which are compatible with a colon origin. Additionally, acute bronchopneumonia is noted. The autopsy was performed for the purpose of determining the presence or absence of

> occupational pneumoconiosis, specifically coal workers' pneumoconiosis. This disease is found in mild form. The manner of death is natural.

(DX 17).

Accordingly, Dr. Hansbarger's autopsy report clearly indicates that the miner died of metastatic colon cancer which metastasized to the lungs. Furthermore, it specifies autopsy findings of "mild to moderate" or "mild" coal worker's pneumoconiosis. Dr. Hansbarger's opinion, if credited, clearly indicates that pneumoconiosis was not the primary cause of the miner's death. In addition, it neither precludes nor establishes the possibility that pneumoconiosis may have substantially contributed or hastened the miner's death.

Dr. R. Paul Bennett, who had been the miner's treating physician, issued a cursory, "To Whom It May Concern" letter, dated November 30, 1999 (DX 16/40). The full text of the letter is as follows:

> I am in receipt of the autopsy report on James Virgil Ray. The autopsy was dated September 7, 1999. Mr. Ray was a regular patient of mine for many years and had a clinical diagnosis of Chronic Obstructive Pulmonary Disease with a history of coal mine employment, consistent with Pneumoconiosis. At the time of Mr. Ray's death an autopsy was performed to document the presence of coal worker's Pneumoconiosis. The autopsy report did indeed show this diagnosis. I would like to present this as evidence of his condition.
>
> He did have manifestations of Chronic Pulmonary Disease and was disabled in regard to his lung problems and I feel that this should be definitive evidence of the presence of coal worker's Pneumoconiosis.

(DX 16/40).

In a supplemental letter, dated September 7, 2000, Dr. Bennett responded to questions posed by a U.S. Department of Labor claims examiner. The full text of this letter is as follows:

> In specific regard to the questions you have raised in regard to Mr. Ray's claim for Coal Workers' Pneumoconiosis benefits; it is my considered opinion that although Mr. Ray did not die directly as a result of Coal Workers' Pneumoconiosis, but rather his metastatic colon cancer, that his pulmonary condition did indeed hasten his death. The rationale for my opinion is the fact that Mr. Ray's overall condition had shown some deterioration for several years prior to the diagnosis of his colon carcinoma. His pulmonary condition was such that he was unable to be involved in any more than minimal activities because of his shortness of breath. As a result of this lack of activity, there was a general overall deterioration of his physical status. This was a direct result of his pulmonary problems.
>
> It is also my considered opinion that Mr. Ray indeed has met all the criteria for benefits as allowed by the Coal Workers' Pneumoconiosis and I hope my letter will help you in

perceeding (sic) in awarding of his claim.

(DX 42).

Dr. Bennett issued a another supplemental report, dated November 6, 2002, in which he sought to address questions posed by Claimant's legal representative regarding the miner's pulmonary condition and its relationship to his death (CX 1). In summary, Dr. Bennett reported the following: he had treated the miner over the course of approximately 14 years beginning in July 1985 until his death; he reviewed his own medical records, consulting reports, the autopsy report, and the death certificate which he had signed; Mr. Ray had a 27 year history of underground mining ending in 1982, and was exposed to coal dust in all the positions he held; he treated the miner for a variety of medical problems including shortness of breath with minimal exertion, wheezing, coughing, pleurisy, increased sputum production, emphysema, hypertension, hyperlipidemia, occasional chest pain with exertion, peptic ulcer disease with acute gastrointestinal bleeding, and colon cancer. Dr. Bennet also reported that he had previously examined the miner, in 1976, before he became Mr. Ray's family physician, and he diagnosed pneumoconiosis.[4] Furthermore, Dr. Bennett cited a State Black Lung Board finding in 1976 of "occupational pneumoconiosis in advanced stage" with a resulting 15% disability award. In addition, Dr. Bennett noted the miner's carotid obstruction in 1992 which required surgery; persistent elevated cholesterol; and, hypertension. Finally, Dr. Bennett reported: "In 1998 Mr. Ray developed onset of rectal bleeding and subsequent testing revealed colon carcinoma with lung metastases. Mr. Ray died in 1999." (CX 1). Based upon the foregoing, Dr. Bennett concluded:

> In my opinion Mr. Ray did have coal workers' pneumoconiosis which was as a direct result of chronic exposure to coal dust from his coal mine employment. He did have a history of smoking approximately one-half pack of cigarettes per day for 30 years. He had quit smoking in 1980. I believe that the coal mine employment was the primary cause of his lung problems but that the cigarette smoking may have aggravated his primary problem. There is no way to determine precisely how much contribution the coal dust and smoking each made to this COPD, but his amount of smoking and time he smoked were certainly not comparable to his long history of coal dust exposure. Consequently I firmly believe that Mr. Ray's chronic lung condition were substantially related to his occupational exposure to coal mine dusts.

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[4] In an earlier report, dated September 7, 1990, Dr. Bennett stated that he had "been the treating physician intermittently for Mr. Ray since July of 1976 (DX 33). In that report, Dr. Bennett stated that the miner's "current problems include Chronic Obstructive Pulmonary Disease with both clinical and x-ray evidence of Pneumoconiosis." In addition, Dr. Bennett noted that the miner "has shortness of breath with minimal excertion (sic) with episodes of wheezing and some increased sputum production." Furthermore, Dr. Bennett concluded that there had been no improvement in Mr. Ray's condition since his original award of Social Security Disability; and, he did not feel the miner could return to his previous employment nor that the miner could be trained to improve his employability (DX 32). I note, however, that Dr. Bennett's report does not specify the clinical test results which underlie his opinion. Furthermore, the miner's prior smoking history is not even mentioned (DX 32).

> In my medical opinion Mr. Ray's death was hastened and contributed to by his pneumoconiosis and COPD although the immediate cause of his death was the colon cancer with lung metastases.
>
> I agree completely with the autopsy prosector that Mr. Ray suffered from pneumoconiosis. It is noted that his findings included a "markedly pigmented" lung with "diffuse pigmentation of the pleural surfaces, parenchyma, and bronchial lymph nodes." It was also noted that there were "scattered throughout the lung parenchyma are noted numerous deposits of anthracotic pigment with reactive fibrosis." Dr. Hansbarger had also noted "Coal maculae...up to 0.2 cm. in greatest dimension." I respectfully disagree with the conclusions of Drs. Fino, Oesterling, Bush, and Naeye. They have taken only limited slide material that was given to them and made conclusions about the total picture. Reviewing their findings reveal that they were presented with only 12 slides for microscopic analysis of an organ that weighed over 1000 grams (approaching 3 lbs). Correlating the microscopic findings to a patient's overall condition is inappropriate and certainly Mr. Ray's pulmonary impairment was more apparent to me since I was physically seeing him on a regular basis. In my 25 years experience of working in an area that has many patient (sic) with pulmonary disease, the lung impairment by pulmonary diseases such as pneumoconiosis cause a deterioration in the overall health of the patient, which in turn, can render them less capable of fighting other debilitating diseases. During the many years that I cared for Mr. Ray he showed gradual deterioration of his overall health that I related to his lung problems. He was unable to exercise or participate in many activities because of his lung disease. All of these would have have (sic) made him stronger and healthier. The pneumoconiosis had led to a continuing decrease in pulmonary function which was years prior to his diagnosis of colon cancer. It is my feeling that this rendered him less capable of fighting his cancer and hastened his death. As a result it is my belief that pneumoconiosis hastened and/or contributed to his death.
>
> With a reasonable degree of medical certainty, I conclude that Mr. Ray's death was caused, at least in part, by his exposure to and inhalation of coal mine dusts, and that both pneumoconiosis and COPD contributed significantly to his death.

(CX 1).

In his deposition testimony on December 4, 2001 (CX 2), Dr. Bennett stated that he entered the practice of medicine in July 1975; he has been Board-certified in Family Practice since 1977; and, he quit practicing medicine in July 2000 (CX 2, pp. 3-4). Dr. Bennett testified that the miner's biggest problem was metastatic colon cancer; however, Dr Bennett stated that he included pneumoconiosis, rather than other medical problems, on the death certificate for the following reason (CX 2, pp. 22-25):

> Because I felt that that [pneumoconiosis] had an impact on his life and, also, his disability in his last weeks and months, because of his chronic obstructive pulmonary disease and his weakened condition, to be able to actually fight off the cancer.

(CX 2, p. 25). I note, however, that Dr. Bennett reached this conclusion even though he not see Mr. Ray during the last six months of the miner's life (CX 2, pp. 25).

In a supplemental report, dated January 17, 2003 (CX 9), Dr. Bennett stated that he had reviewed additional medical records, including reports by Drs. Perper, Bush, Oesterling, Castle, and Fino. Following his discussion of various medical data, Dr. Bennett stated:

> In conclusion, I support the findings of Dr. Perper and feel that his interpretation of the evidence presented most closely fits the clinical picture that I dealt with while caring for Mr. Ray. I disagree with the conclusions of Drs. Zaldivar, Bush, Oesterling, Castle, and Fino. Further, it continues to be my professional opinion with a reasonable degree of medical certainty that Mr. Ray suffered from chronic obstructive pulmonary disease and pneumoconiosis caused, in (sic) least in part, by his exposure to an inhalation of coal dust during his 30 years spent as an underground coal miner. Further I continue to believe that his lung disease contributed to and hastened his death.

(CX 9).

Dr. Richard L. Naeye has been Board-certified in Anatomic and Clinical Pathology since 1956 (DX 37); he is still actively practicing as a pathologist in association with the medical school and teaching hospital at Hershey Medical Center (EX 4, pp. 3-4). In a report, dated September 8, 2000 (DX 37), Dr. Naeye reviewed a brief letter from Dr. Bennett, the miner's death certificate, the autopsy report by Dr. Hansbarger, and, 12 pathology slides containing lung tissue. Following a summary of the above-referred medical data, and his microscopic examination of the slides, Dr. Naeye concluded:

> INTERPRETATIONS: The microscopic findings of a very mild, simple coal worker's pneumoconiosis are present. Its major features are a small number of anthracotic macules with accompanying fibrosis. Focal emphysema is rare. These findings meet the minimum requirements for the diagnosis of mild, simple coal worker's pneumoconiosis (CWP). This CWP is far too mild to have caused any measurable impairments in lung function or any disability that would have prevented him from mining coal. It is also far too mild to have hastened or otherwise had any role in his death. Death was entirely due to complications of the metastatic adenocarcinoma that originated this man's colon. Complications of the adenocarcinoma were a pulmonary arterial embolus and a severe, rapidly spreading acute lobular pneumonia. Occupational exposure to coal mine dust does not predispose to the development of adenocarcinoma in the colon.

(DX 37).

In his deposition testimony on June 19, 2002 (EX 4), Dr. Naeye stated that he understood that Mr. Ray had worked as an underground coal miner for 33 years, primarily as a mechanic and electrician. Dr. Naeye, again, discussed his own microscopic findings. He also noted that the x-ray evidence had not established the existence of coal workers' pneumoconiosis, but the autopsy evidence is a much more sensitive tool; and, it showed minimal pneumoconiosis, as well as focal emphysema. In summary, Dr.

Naeye testified:

> ...Once the cancer gets into your lungs, it's usually (sic) the survival time is months, not more than a year or two at the most. Even if the cancer responds to therapy, it would be unusual for someone to live more than a year or two. That would be uncommon.

(EX 4, p. 28). Furthermore, Dr. Naeye confirmed that the simple pneumoconiosis was too mild in this case to have caused or even hastened the miner's death (EX 4, p. 28).

In a supplemental report, dated November 14, 2002 (EX 5), Dr. Naeye stated that he had reviewed additional medical records, including a copy of his own deposition, a consultation letter and deposition transcript of Dr. Bennett, results of a graded exercise test, and, the West Virginia Occupational Board findings. Following his discussion of the additional medical data, Dr. Naeye stated:

> In my original report on this case and in the reports of other pathologists the lung tissues available for microscopic examination had multiple anthracotic macules with associated fibrosis but no tiny birefringent crystals of toxic free silica. The first responsibility of pathologists in day to day practice is to make diagnoses. This usually leads to select the most damaged tissues they can find for microscopic review. Their reports thus very often *overdiagnose the severity of the disease.* Dr. Bennett's premise in the current case is that the tissues taken for microscopic diagnosis were selected because they contained only a few, very small CWP lesions (anthracotic macules) whereas larger and perhaps more frequent lesions existed elsewhere. Based on my microscopic reviews of tissues from several thousand lungs of ex-coal miners Dr. Bennett's premise is the reverse of what takes place in practice. It needs also to be recognized that chest X-rays of James Ray found lesions mainly in the lower lobes of miner's lungs. In addition to the above there were no very tiny birefringent crystals of toxic free silica in his lung tissues. Without such free silica being present, CWP lesions rarely expand over the years and there is no X-ray evidence that such lesion expansion took place in his lungs.
>
> Finally, the apparent deterioration in late years of this man's lung function was almost certainly the consequence of his cigarette smoking. There is no doubt that coal mine dust exposure as well as smoking cigarettes can lead to chronic bronchitis, and less often to chronic bronchiolitis. However, studies of randomly selected populations of coal miners have shown no effect of mine dust exposure on life expectancy. Such expectancy would surely have been reduced if exposure to coal mine dust had caused clinically significant centrilobular emphysema, chronic bronchitis and chronic bronchiolitis. However, studies by Fletcher et al, Bates et al, and Foxman et al indicate that bronchitis has little or no effect on lung function unless the subject happens to be a smoker. *Airway obstruction caused by centrilobular emphysema and bronchitis that is severe enough to preclude a miner from working is very rare if it indeed occurs at all in the absence of smoking or complicated CWP.* Studies have also shown that chronic cor pulmonale does not occur in coal miners in the absence of cigarette smoking. In summary there is no evidence in this case that the very mild simple CWP that was present caused any disability, contributed to or hastened his

death.

(EX 5)(Emphasis in original)(Footnotes to medical literature omitted).

Dr. Stephen T. Bush has been Board-certified in Anatomic and Clinical Pathology and Medical Microbiology since 1969 and 1978, respectively (DX 38). In his report, dated October 3, 2000, Dr. Bush stated that he had reviewed Dr. Shank's (1983) pulmonary evaluation; a 1984 ventilatory study; Dr. Zaldivar's (1984) pulmonary evaluation; Dr. Zaldivar's (1984) letter; Dr. Hansbarger's autopsy report; the death certificate; Dr. Bennett's (1999) letter; Dr. Naeye's (2000) report; and the histologic slides. Based upon the foregoing, Dr. Bush stated: the lungs show evidence of a very mild degree of simple coal workers' pneumoconiosis; the very mild degree of coal worker's pneumoconiosis did not contribute to the miner's death; the miner did not suffer from respiratory impairment prior to death; Mr. Ray was totally disabled prior to death from his carcinoma of the colon with metastasis; the very mild degree of simple coal workers' pneumoconiosis or occupational coal dust exposure did not contribute to respiratory impairment or disability; and, coal workers' pneumoconiosis or coal dust exposure played no role in nor hastened the miner's death. Finally, Dr. Bush stated, in pertinent part:

> ...Mr Ray would have died at the same time and in the same manner if he had never been exposed to the pulmonary hazards of coal mining employment. Carcinoma of the colon is no more common in coal miners than in the general population.
>
> Dr. Bennett concluded that Mr. Ray had disabling coal workers' pneumoconiosis, but his letter does not state the basis for such an opinion. It is true the autopsy indicates coal workers' pneumoconiosis, but this is present in too limited a degree and extent to have caused pulmonary impairment or disability.
>
> My opinion and conclusions regarding the clinical and pathologic findings are in agreement with those of Dr. Hansbarger, who performed the autopsy, and Dr. Naeye, who reviewed the autopsy and clinical materials. These findings are consistent with the pulmonary evaluations of Dr. Zaldivar and Dr. Shank.

(DX 38).

Dr. Bush issued a supplemental report, dated December 4, 2002, in which he reviewed and analyzed reports by Drs. Cohen and Perper, respectively. Dr. Bush did not find the opinions of Dr. Cohen and/or Dr. Perper persuasive, and reiterated that his own conclusions are not in any way influenced thereby (EX 11).

Dr. Everett F. Oesterling has been Board-certified in Anatomical Pathology, Clinical Pathology, and Nuclear Medicine, since 1966, 1968, and 1972, respectively (DX 39). In his report, dated November 10, 2000, Dr. Oesterling reviewed medical data supplied by Employer's representative, and analyzed the histologic slides (DX 39). In order to document and illustrate his findings, Dr. Oesterling utilized photomicrophages, which he referred to in his report. Following his detailed analysis of the pathology evidence as shown on the photomicrophages, Dr. Oesterling discussed other medical data and reached the

following conclusion:

> Based on my examination of the tissues and record review, I would conclude with reasonable degree of medical certainty that this gentleman suffered no significant lifetime disability due to mine dust exposure, nor did his history of employment within the mining industry result in any disease process which hastened and/or contributed to his death.

(DX 39).

Dr. Oesterling issued a supplemental report, dated November 21, 2002, in which he reviewed and analyzed additional materials including a letter and deposition testimony of Dr. Bennett (EX 6). In summary, Dr. Oesterling stated, in pertinent part:

> In concluding, Dr. Bennett's letter and his testimony indicate that he indeed is a knowledgeable and caring clinician. Unfortunately, clinicians must work with indirect measures in assessing pulmonary impairment. Again I would state that the gold standard for this evaluation is the microscopic examination of lung tissue. Therefore, my conclusions as stated on November 10, 2000 remain unchanged. I would conclude with reasonable medical certainty that this gentleman suffered no significant lifetime disability due to mine dust exposure, nor did his history of employment within the mining industry result in any disease process which hastened and/or contributed to his death.

(EX 6).

Dr. Gregory J. Fino is a B-reader who has been Board-certified in Internal Medicine and Pulmonary Disease, since 1979 and 1982, respectively (DX 47). Dr. Fino issued a detailed report, dated January 10, 2001, in which he reviewed the available medical evidence (DX 47). Based upon the foregoing, Dr. Fino set forth the following conclusions:

> 1. Simple coal workers' pneumoconiosis was present pathologically.
>
> 2. There was no evidence of any disabling respiratory impairment caused by coal mine dust inhalation or cigarette smoking.
>
> 3. This man was disabled as a whole individual due to metastatic colon cancer which had spread to the lungs. However, this disability was not caused, in whole or in part, by the inhalation of coal mine dust.
>
> 4. Coal mine dust inhalation was not a discernible participating cause of this man's whole man disability or his death.
>
> 5. Coal mine dust inhalation did not cause, contribute to, or hasten his death.
>
> 6. This man would have died as and when he did had he never stepped foot in the mines.

(DX 47).[5]

Dr. Fino issued a supplemental report, dated November 14, 2002, in which he reviewed and analyzed additional medical data, including: a positive (1/0)chest x-ray reading of a film, dated October 1, 1976; the Occupational Pneumoconiosis Board Findings, dated December 13, 1977, which concluded that the miner had occupational pneumoconiosis and a 15% functional pulmonary impairment; an exercise study, dated February 20, 1985; Dr. Bennett's deposition transcript, dated December 4, 2001; and Dr. Bennett's medical letter, dated November 6, 2002. Following a summary of the objective findings as set froth in a "Flow Sheet" and a summary of the reported occupational and smoking histories, Dr. Fino reiterated the opinions which he had previously set forth in his report, dated January 10, 2001 (EX 5).

Dr. George L. Zaldivar is a B-reader who has been Board-certified in Internal Medicine, Pulmonary Diseases, Sleep Disorder Medicine, and Critical Care Medicine, since 1974, 1978, 1989, and 1995, respectively (EX 1). Dr. Zaldivar issued a report, dated March 19, 2001, in which he reviewed the available medical evidence (EX 1). Based upon the foregoing, Dr. Zaldivar set forth the following conclusions:

> 1. There is sufficient objective evidence to justify a diagnosis of coal workers' pneumoconiosis in this case.
> 2. There was a respiratory impairment present. The respiratory impairment present was very mild and, in my opinion, was caused by his past smoking habit. The respiratory impairment was of no clinical significance whatsoever.
> 3. From the pulmonary standpoint as of the time of his last valid breathing test, Mr. Ray did not have any clinical pulmonary impairment, which would prevent him from performing his usual coal mining work, or work requiring similar exertion. From the pulmonary standpoint, he was fully capable of performing his usual coal mining work.
> 4. As a whole man, prior to his death, Mr. Ray was not capable of performing any work because of the nature of his disease, which was metastatic colon cancer to the lungs and presumably other organs as well.
> 5. Coal mine dust exposure did not play any role in disability prior to his death. The disability was due to metastatic colon cancer.
> 6. Coal workers' pneumoconiosis did not play any role in the death of Mr. Ray. It did not cause, nor hasten his death.

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[5] The case file reflects that Dr. Fino had issued an earlier report, dated September 11, 1989, in which he had also reviewed the available data. At that time, Dr. Fino did not find sufficient objective evidence to warrant a diagnosis of coal worker's pneumoconiosis. In addition, Dr. Fino noted that the miner only had a "mild clinically insignificant respiratory impairment," which was not totally or even partially disabling. On the other hand, Dr. Fino concluded that the miner was totally disabled by cardiac disease (DX 50-55).

(EX 1).[6]

In his deposition testimony on June 18, 2002 (EX 3), Dr. Zaldivar discussed the relevant medical evidence and the mechanism of death. Based upon his analysis, Dr. Zaldivar reiterated that, even if the miner's lungs had been perfect, he would not have survived any longer. While noting that Mr. Ray's lungs only reflected a mild abnormality due to chronic obstructive airway disease, Dr. Zaldivar opined that the cancer would have spread in the same manner; and, Mr. Ray had no chance of survival. Accordingly, Dr. Zaldivar concluded that the simple pneumoconiosis did not contribute nor hasten the miner's death (EX 3, p. 31).

Dr. Zaldivar issued a supplemental report, dated November 18, 2002, in which he reviewed and analyzed various additional medical data, including, but not limited to, the following: his own report and records regarding Mr Ray; x-rays from 1995 and 1996 consistent with emphysema, but not pneumoconiosis; his own deposition; Dr. Naeye's report; various autopsy reports; and, the reports and deposition testimony of Dr. Bennett. Based upon his review and further analysis, Dr. Zaldivar concluded that his "opinion remains exactly the same as previously given." (EX 6).

In another supplemental report, dated November 26, 2002 (EX 10), Dr. Zaldivar reviewed additional medical records, including the reports and analyses of Dr. Cohen and Dr. Perper, respectively. Following his discussion of the foregoing opinions, Dr. Zaldivar set forth the following conclusions:

1. There is evidence in this case to justify a diagnosis of coal workers' pneumoconiosis because such was found on autopsy, although the x-rays did not reveal any visible pneumoconiosis.

2. There was a pulmonary impairment present. The impairment was very mild and never caused any of the physicians to treat it, even when there was a large cancer burden in the lungs. Therefore, the lung reserve was excellent and, therefore, there was no need to treat the very mild obstruction which was found in 1984. This mild pulmonary impairment, due to smoking, was not significant and, in itself, would not have prevented Mr. Ray from performing his usual coal mining work or work requiring similar exertion.

3. From the pulmonary standpoint, just prior to his death, Mr. Ray did not have the

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[6] The record shows that Dr. Zaldivar had examined the miner on August 15, 1984. He issued a History and Physical Examination report and a report, dated October 1, 1984 (DX 50-33).
At that time, Dr. Zaldivar reported mild irreversible obstructive airway impairment by spirometry; and carbon monoxide diffusing capacity, resting blood gases, and physical findings on examination which were all "normal." In addition, Dr. Zaldivar found no x-ray evidence of pneumocniosis. In summary, Dr. Zaldivar opined that the miner's "very small" pulmonary impairment would not prevent him from even heavy physical labor. However, Mr. Ray is "severely impaired from heart disease which is unrelated to mine work." (DX 50-33).

pulmonary capacity to perform his usual coal mining work due to the large cancer burden in his lungs and the blood clots which were found. Terminally, a pneumonia occurred as well due to generalized weakness and wasting caused by the cancer.

4. Mr. Ray's dust exposure did not play any role in any disability prior to his death.

5. The coal worker's pneumoconiosis that was found by the pathologists did not play any role in his death. This same coal worker's pneumoconiosis did not hasten his death nor cause it.

6. Based on all the information that I have reviewed, Mr. Ray would have died exactly when and as he did, even if he had never worked in the coal mines. Death was due to metastatic colon cancer and its physiologic consequences.

(EX 10).

Dr. James R. Castle is a B-reader who has been Board-certified in Internal Medicine and Pulmonary Disease since 1972 and 1976, respectively (EX 1). Dr. Castle issued a report, dated October 18, 2001, in which he reviewed the available medical evidence (EX 1). Based upon his analysis, Dr. Castle stated, in pertinent part:

> ...(I)t is my opinion with a reasonable degree of medical certainty that Mr. James Ray did have pathologic evidence of minimal, simple coal workers' pneumoconiosis.
>
> It is my opinion with a reasonable degree of medical certainty, based upon a thorough review of all the data, that Mr. Ray was not permanently and totally disabled by the simple coal workers' pneumoconiosis that was present radiographically. The valid pulmonary function studies that were done after leaving the mining industry did not indicate pulmonary impairment significant enough to cause disability from any cause. While it is true that he was very likely disabled as a result of metastatic adenocarcinoma to the lungs prior to his death, this finding is unrelated to his previous coal mining employment and coal dust exposure. Therefore, as a whole man, he was disabled prior to death due to metastatic adenocarcinoma of the colon. It is also possible that he was disabled during life due to significant coronary artery disease with angina pectoris. However, this is a disease of the general public at-large and is unrelated to coal mining employment and coal dust exposure.
>
> It is my opinion with a reasonable degree of medical certainty based upon a through review of all the data that Mr. James Ray died as a result of metastatic colon cancer. He died as a result of complications of this process. His death was neither caused by, contributed to, or hastened in any way by the underlying coal workers' pneumoconiosis that was present pathologically. He would have died as and when he did regardless of his occupational history and coal dust exposure.

(EX 1).

In his deposition testimony on June 10, 2002 (EX 3), Dr. Castle discussed the pertinent medical data Based upon his analysis, Dr. Castle reiterated that: the miner died of metastatic colon cancer which had metastasized to the lungs and possibly elsewhere; there is no evidence in the medical literature that coal worker's pneumoconiosis or coal dust exposure increases the risk of colon cancer or lung cancer; and, Mr. Ray's simple coal worker's pneumoconiosis did not cause, contribute, nor hasten the miner's death in any way (EX 3, pp. 24-25).

Dr. Castle issued a supplemental report, dated November 19, 2002, in which he reviewed and analyzed various additional medical data, including, but not limited to: his own deposition testimony; a 1985 exercise test; a 1976 positive (1/0) x-ray finding for pneumoconiosis; and, a report and deposition of Dr. Bennett, and, other negative x-ray and CT scan evidence. Based upon his review and further analysis, Dr. Castle reiterated his conclusions, stating, in pertinent part:

> It continues to be my opinion with a reasonable degree of medical certainty that Mr. Ray would have died as and when he did regardless of whether he had pathologic evidence of coal workers' pneumoconiosis or not. His death was neither caused by, contributed to, or hastened in any way by the underlying coal workers' pneumoconiosis that was present pathologically.

(EX 5).

In another supplemental report, dated December 6, 2002 (EX 13), Dr. Castle reviewed additional medical records, including his own report, dated November 19, 2002, and the reports and analyses of Dr. Cohen and Dr. Perper, respectively. Following his discussion of the foregoing opinions, Dr. Castle concluded:

> After reviewing all the additional medical data noted above, I would have the following comments and opinions. A review of this data has not altered any of my previously stated opinions. It is my opinion that Mr. Ray did have pathologic evidence of simple coal workers' pneumoconiosis. He did have some degree of pulmonary emphysema described as minimal to moderate (Dr. Perper indicated moderate-severe). Nevertheless, he did not have any valid physiologic studies indicating a disabling respiratory impairment. Both Drs. Cohen and Perper speculated that he would have been disabled based on his lung disease during his life. There is no objective data to support that conclusion from a physiologic pont of view. The last valid pulmonary function studies performed by Dr. Zaldivar in 1984, some two years after he left the mining industry, showed only mild airway obstruction. While both noted that he had significant symptoms, it is interesting that in July 1998 Dr. Coonley indicated that Mr. Ray had no shortness of breath or hemoptysis. On June 30, 1999, Dr. Coonley again noted that Mr. Ray had no shortness of breath or cough. He was beginning to complain of some constipation at that time. Therefore, it remains my opinion that there was no objective evidence of a disabling respiratory impairment during life.

> It continues to be my opinion that Mr. Ray's death was neither caused by, contributed to, or hastened in any way by the underlying coal workers' pneumoconiosis that was present. It continues to be my opinion that Mr. Ray died as a result of complications from metastatic colon cancer. Dr. Perper postulated that the underlying pneumoconiosis precipitated a fatal arrhythmia. There is no evidence to support that fact. He indicated that fatal arrhythmias are more common in people with COPD in exacerbation. While this is true, there is no evidence that Mr. Ray had significant clinical health problems related to COPD and there is clearly no evidence that he was having an exacerbation of COPD. It remains clear that Mr. Ray had a terminal illness consisting of metastatic colon cancer. Terminally, he developed bronchopneumonia, an extremely common event in cancer patients, and had pulmonary thromboemboli. Colon cancer is a known predisposing factor in the development of vascular thrombosis and pulmonary thromboembolic disease. None of these conditions are related to coal workers' pneumoconiosis. It remains my opinion that Mr. Ray would have died as and when he did regardless of the underlying coal workers' pneumoconiosis.

(EX 13).

Dr. David M. Rosenberg is a B-reader who has been Board-certified in Internal Medicine Pulmonary Disease , and Occupational Medicine since 1977, 1980, and 1995, respectively (DX 48). Dr. Rosenberg issued a report, dated December 27, 2001, in which he reviewed the available medical evidence (DX 48). Based upon his analysis, Dr. Rosenberg stated:

> In **CONCLUSION**, it can be stated with a reasonable degree of medical certainty, that Mr. Ray had very simple CWP. He had no significant impairment consequent to this pneumoconiosis, and from a respiratory perspective, he could have performed his previously defined coal mining job or other similar arduous types of labor prior to his death. While as a whole he suffered the reduced capacity to perform his usual coal mine employment prior to his death, this disability is related to his metastatic colon cancer, which bore no relationship to the past inhalation of coal mine dust or the presence of CWP. In addition, CWP or coal mine dust exposure did not etiologically play any role or hasten his death.

(DX 48).

In a supplemental report, dated November 19, 2002 (EX 5), Dr. Rosenberg stated that he had reviewed additional medical records, including a medical report by Dr. Bennett, an exercise test, a chest x-ray, the Occupational Pneumoconiosis Board findings; and, Dr. Bennett's deposition. Following his further discussion of the medical data, Dr. Rosenberg reiterated his findings as set forth above; namely, that Mr. Ray's mild simple CWP did not cause any significant impairment; and, the miner's "death bore no relationship to the past inhalation of coal mine dust exposure or the presence of CWP." (EX 5).

Dr. Robert A.C. Cohen is a B-reader who has been Board-certified in Internal Medicine and Pulmonary Disease since 1986 and 1988, respectively (CX 3). Dr. Cohen issued a report, dated November 13, 2002, in which he reviewed the available medical evidence (CX 3). Based upon his analysis, Dr. Cohen stated:

Conclusion

> The sum of the medical evidence in conjunction with this patient's work history indicates that this patient's 27 years of coal mine dust exposure and 11 pack year exposure to tobacco smoke was significantly contributory to the development of his obstructive lung disease and emphysema. His coal mine dust exposure also resulted in the development of interstitial lung disease in the form of coal macules and micronodules. These diseases resulted in significant impairment that was disabling for his job as an electrician, and also hastened his death from colon cancer, pneumonia, and pulmonary thromboemboli.

(CX 3).

In a supplemental report, dated January 27, 2003 (CX 8), Dr. Cohen reviewed additional medical data, including various medical opinions by Drs. Zaldivar, Bush, Oesterling, Castle, and Fino, particularly regarding their commentary on a report by Dr. Perper. Following his analysis of the data, Dr. Cohen repeated, almost verbatim, the conclusion which he had previously set forth in his report, dated November 13, 2002 (CX 8; *Compare* CX 3).

On February 9, 2003, Dr. Cohen issued a second supplemental report, in which he evaluated additional reports by Drs. Zaldivar, Bush, and Castle. Notwithstanding the contrary conclusions set forth by the above-listed physicians, Dr. Cohen reiterated his previously stated conclusions (CX 10).

Dr. Joshua A. Perper has been Board-certified in Anatomical and Surgical Pathology, as well as Forensic Pathology since 1972. In addition, he obtained in law degree in 1966 (CX 4).
On November 18, 2002, Dr. Perper issued a lengthy report (CX 4), in which he provided a detailed summary of various data. Furthermore, Dr. Perper provided his own findings on microscopic examination of the autopsy tissue, and answered various questions. In addition, Dr. Perper included some references to medical literature, including an appendix which discussed "Coal workers' pneumoconiosis and associated centri-lobular emphysema;" and, he included a "Legend of microphotographs of lung sections from autopsy of James V. Ray." In summary, Dr. Perper concluded:

> 1. Mr. Ray had evidence of excessively long standing occupation exposure to coal mine dust and inconvertible evidence of simple coal workers' pneumoconiosis at autopsy.
>
> 2. Mr. Ray, a coal miner with an occupational exposure of more than thirty (30) years of coal mining, most of them underground, developed coal workers' pneumoconiosis as a result of occupational exposure to coal mine dust.
>
> 3. Although the metastatic cancer of the lung was a primary cause of death, coal workers' pneumoconiosis with associated centrilobular emphysema, was a substantial contributory cause and a hastening factor of Mr. Ray's (sic) both directly and indirectly through hypoxia triggering or facilitating a fatal arrhythmia, and together with the pulmonary cancer increasing the susceptibility of the miner to pulmonary infections and bronchopneumonia.

(CX 4).

In a supplemental report, dated January 21, 2003, Dr. Perper sought to address the comments and criticisms of his opinion which had been set forth in various reports by Drs. Zaldivar, Bush, Oesterling, Castle, and Fino (CX 7). Following his discussion of the foregoing opinions, Dr. Perper stated:

> 1. A detailed analysis of the critical remarks and comments included in the supplemental reports of Drs. Naeye, Bush, Oesterling and Castle, failed to identify any valid critical findings or arguments of my findings and opinions stated in my November 18, 2002 report, with the exception of a minor and almost self-evident typographical error.
>
> 2. Dr. Fino's supplemental report included no critical remarks or comments and therefore requires no further discussion.
>
> 3. Based on the review and analysis of the above submitted supplemental records, I found no reasonable grounds to change my Findings and opinions as expressed in my report of November 18, 2002.

(CX 7).

In his deposition testimony on March 26, 2003(EX 15), Dr. Perper acknowledged that he didn't know the frequency of the miner's visits to Dr. Bennett (EX 15, 25). Moreover, he incorrectly stated: "I think he [Dr. Bennett] saw him just, perhaps, less than a month before his - - before the patient's death (EX 15, p. 26). In fact, Dr. Bennett testified that he did not see the miner after March 1999 (*i.e.*, six months prior to Mr. Ray's death)(*Compare* CX 2, pp. 23,25). Furthermore, when asked whether Dr. Bennett administered any clinical tests to show COPD or shortness of breath, Dr. Perper simply responded: "Not that they are documented in my report." (EX 15, p. 26). Furthermore, Dr. Perper stated that he prefers the opinion of the treating physician who wrote letters after Mr. Ray's death over the clinical notes of the treating oncologist (EX 15, 26). In summary, based upon his evaluation of the evidence, Dr. Perper reiterated that Mr. Ray suffered from a disabling pulmonary impairment during his lifetime, as found by Dr. Bennett. Furthermore, in conjunction with the autopsy evidence of pneumoconiosis, emphysema, and associated COPD, Dr. Perper reiterated his opinion that these coal mine related conditions made the miner more susceptible to pneumonia and other bronchial diseases. Accordingly, Dr. Perper, again, stated that pneumoconiosis contributed to or hastened Mr. Ray's death (EX 15, pp.40- 46).

Discussion and Applicable Law

As set forth above, the Employer stipulated, and I find, that Mr. Ray had simple pneumoconiosis, which arose from his 25+ years of coal mine employment. However, in order to be eligible for benefits, Claimant must also establish that the miner's death was due to pneumoconiosis, as provided in the Act and applicable regulations.

Death due to Pneumoconiosis

Since the claim was filed after January 1, 1982, the issue of death due to pneumoconiosis is governed by § 718.205(c), as amended, which states, in pertinent part:

> For the purpose of adjudicating survivor's claims filed on or after January 1, 1982, death will be considered to be due to pneumoconiosis if any of the following criteria is met:
>
> (1) Where competent medical evidence establishes that pneumoconiosis was the cause of the miner's death, or
>
> (2) Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis, or
>
> (3) Where the presumption set forth at § 718.304 is applicable.
>
> (4) However, survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death.
>
> (5) Pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death.

20 C.F.R. § 718.205(c).

As outlined above, the credible medical evidence establishes that the miner died as a result of metastatic colon cancer, and complications therefrom. Furthermore, there is no credible evidence of complicated pneumoconiosis. Therefore, I find that Claimant has clearly failed to establish "death due to pneumoconiosis" under §718.205(c)(1) and (3). Accordingly, the crux of this case is whether or not the miner's found simple coal worker's pneumoconiosis substantially contributed and/or hastened the miner's death. *See* 20 C.F.R. §718.205(c)(2), (4), (5).

As set forth above, the record includes the medical opinions of Drs. Hansbarger, Bennett (DX 16/40,42; CX 1,2,9), Naeye (DX 37; EX 4,5), Bush (DX 38; EX 11), Oesterling (DX 39; EX 6), Fino (DX 47; EX 5), Zaldivar (EX 1,3,6,10), Castle (EX 1,2, 5,13), Rosenberg (DX 48; EX 5), Cohen (CX 3,8,10), and Perper (CX 4,7; EX 15), which address the cause of death.

Dr. Hansbarger, who performed the autopsy, listed coal worker's pneumoconiosis among various diagnosed conditions. Furthermore, he described the disease as "mild to moderate" and "in mild form." However, Dr. Hansbarger clearly stated that Mr. Ray "died as a result of metastatic adenocarcinoma of the colon with metastasis to the lungs;" and, he described "extensive tumor deposits...throughout the lungs compatible with a colon origin." (DX 7). Since Dr. Hansbarger's opinion does not specify that the miner's simple pneumoconiosis played a role in his death, nor does it specifically preclude such a finding, it

does not directly address the crux of this case; namely, whether pneumoconiosis (clinical or legal) substantially caused and/or hasten Mr. Ray's death.

Of the remaining physicians listed above, only Drs. Bennett, Cohen, and Perper found that the miner's coal worker's pneumoconiosis was a substantially contributing factor in and/or hastened the miner's death. In contrast, Drs. Naeye, Bush, Oesterling, Fino, Zaldivar, Castle, and, Rosenberg found that the miner's relatively mild simple coal worker's pneumoconiosis did not cause, substantially contribute, or hasten the miner's death.

All of the foregoing opinions, including those by Drs. Bennett, Cohen, and Perper, appear, on their face, to be well-reasoned and documented. However, the burden rests with the Claimant to establish the elements of entitlement, including "death due to pneumoconiosis," by a preponderance of the evidence.

Notwithstanding the numerical superiority of those physicians who found pneumoconiosis did not play a role in the miner's death, Claimant contends that controlling weight should be given to Dr. Bennett's opinion, as buttressed by the opinions of Drs. Cohen and Perper, because he was the miner's treating physician.

Pursuant to the provisions of §718.104(d), I must consider the following factors in weighing the opinion of the miner's treating physician: nature of relationship; duration of relationship; frequency of treatment; and, extent of treatment.

As set forth in Dr. Bennett's deposition testimony on December 4, 2001 (CX 2), he first examined the miner in 1976. At that time, Dr. Bennett saw him for hypertension in conjunction with a life insurance physical and/or as part of a black lung physical for a State Black Lung claim (CX 2, p. 14). Apparently during the period from 1976 through 1985, the miner was seen by another physician. Thereafter, the miner returned to Dr. Bennett's practice; and, Dr. Bennett made the diagnoses of chronic obstructive pulmonary disease, chest pain consistent with angina, and osteoarthritis (CX 2, p. 14). Dr. Bennett testified that the miner subsequently developed G.I. problems, including recurrent G.I. bleeding, and continued problems with hypertension. In addition, the miner suffered from episodes of syncope related to an electrolyte imbalance. However, Dr. Bennett primarily saw him regarding the miner's hypertension (CX 2, p. 15). Dr. Bennett noted that forms were completed in conjunction with the miner's claim for Social Security Disability Benefits, and, that he continued to treat the miner for chronic obstructive pulmonary disease. Thereafter, in 1992, the miner developed evidence of a carotid obstruction. Following a transient attack, the miner underwent carotid surgery. The miner was found to have elevated cholesterol. Thereafter, the miner continued to be followed for his hypertension, elevated cholesterol and circulatory problems until 1998. At that time, the miner had rectal bleeding. Following a colonoscopy, it was found that he had obstructive rectal carcinoma and metastatic disease. The miner started being treated, but died in 1999 (CX 2, pp. 15-16). Dr. Bennett last saw the miner in March 1999, when he ordered a CT scan and an MRI to check the status of his metastatic disease before treatment with chemotherapy was considered. Prior thereto, Dr. Bennett saw Mr. Ray in June 1998 (CX 2, pp. 21-22).

In summary, the length of Dr. Bennett's relationship was quite long. However, Dr. Bennett

primarily treated the miner for non-respiratory conditions. Furthermore, the frequency and extent of Dr. Bennett's treatment is unclear from the record. In fact, there is little documentation in evidence regarding clinical tests administered by Dr. Bennett to monitor the progression, if any, of the miner's chronic obstructive pulmonary disease and/or regarding Dr. Bennett's attempts to treat the disease. Moreover, Dr. Bennett did not even see the miner during the last six months of his life. In addition, Dr. Bennett apparently only saw him twice during the last fifteen months of the miner's lifetime. In view of all of the foregoing, I find that Dr. Bennett did not have a superior understanding of the miner's condition, particularly as to the "death due to pneumoconiosis" issue. Finally, although Dr. Bennett was Board-certified in Family Practice in 1977, he quit practicing medicine in July 2000 (CX 2, p. 4), and lacks the specialized credentials in the fields of pulmonary medicine and pathology of the other physicians cited above. Therefore, I accord Dr. Bennett's opinion less weight despite his status as a treating physician.

I have also carefully weighed the medical opinions of Drs. Cohen, and Perper against those of Drs. Naeye, Bush, Oesterling, Fino, Zaldivar, Castle, and, Rosenberg. I note that Drs. Cohen, Fino, Zaldivar, Castle, and, Rosenberg are all well-credentialed Board-certified pulmonary experts; and, Drs. Perper, Naeye, Bush, and Oesterling are well-qualified Board-certified pathologists. Based upon my analysis of the foregoing opinions, in conjunction with other relevant evidence, I find the opinions of Drs. Naeye, Bush, Oesterling, Fino, Zaldivar, Castle, and, Rosenberg are more persuasive.

As outlined above, the record clearly establishes that the miner was hospitalized for rectal bleeding in February 1998. Following a colonoscopy and CT scans of the chest, abdomen, and pelvis, the miner was diagnosed as suffering from rectal carcinoma and probable metastatic lesions to the lungs. Shortly thereafter, Drs. Baker and Coonley issued reports confirming the diagnosis of metastatic colon cancer with pulmonary metastases. Accordingly, in early 1998, Drs. Baker and Coonley both described the disease as incurable. Notwithstanding the pulmonary metastases, Dr. Baker reported, on April 9, 1998, that the miner was "totally asymptomatic." Therefore, he did not even recommend palliative treatment. Similarly, on April 15, 1998, Dr. Coonley reported that he agreed with Dr. Baker's assessment that the miner has an incurable disease. Furthermore, Dr. Coonley specifically stated: "I think we should monitor him for symptoms of his pulmonary metastases such as cough, dyspnea, hemoptysis, etc. and intervene at such time as these lesions produce symptoms." Yet, he, too, reported that the miner was "asymptomatic." Furthermore, on July 15, 1998, Dr. Coonley again reported that the "patient has no shortness of breath or hemoptysis." Moreover, on June 30, 1999 (*i.e.*, less than 2 ½ months prior to the miner's death), Dr. Coonely, again, reported "no shortness of breath or cough," while noting other problems such as constipation (DX 36).

In view of the above-described medical history in the period from the time Mr. Ray was diagnosed with incurable metastatic colon cancer until shortly before his death, as reported by the physicians who assessed his terminal disease, I find that the miner's condition was not compromised by a respiratory or pulmonary impairment. The foregoing medical history in the period immediately leading up to the miner's death also tends to undermine the conclusions of Drs. Cohen and Perper, as well as Dr. Bennett, that the miner suffered from a disabling respiratory or pulmonary impairment due, at least in part, to coal mine dust exposure, which, in turn, substantially contributed to or hastened the miner's death. To the contrary, as found by Drs. Naeye, Bush, Oesterling, Fino, Zaldivar, Castle, and, Rosenberg, I find that the pathology evidence, taken as a whole, only establishes mild simple pneumoconiosis, and, the best reasoned medical

opinions reflect that the valid clinical test results only indicated a mild respiratory impairment if any. Furthermore, the treating physicians shortly before the miner's death reported that he was asymptomatic and did not suffer from shortness of breath less than 2 ½ months before he died. In view of the foregoing, I find that the credible evidence does not establish that pneumoconiosis (clinical and/or legal) substantially contributed to nor hastened the miner's death. The evidence establishes that the miner suffered with an incurable disease (*i.e.*, metastatic colon cancer) and simply succumbed to the disease approximately 1 ½ years after it was first diagnosed. Accordingly, I find that the Claimant has failed to meet his burden of establishing death due to pneumoconiosis under §718.205(c), or by any other means.

Conclusion

Although the evidence established that the miner had simple pneumoconiosis which arose from his 25+ years of coal mine employment, it does not establish that pneumoconiosis caused, substantially contributed to, or hastened the miner's death. Therefore, I find that the Claimant is not entitled to benefits under the Act and applicable regulations.

Attorney's Fees

The award of an attorney's fee under the Act is permitted only in the cases in which Claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for services rendered to him in pursuit of this claim.

ORDER

It is ordered that the claim of Carol A. Ray, surviving spouse of James V. Ray, for black lung benefits under the Act is hereby **DENIED**.

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RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal to the Benefits Review Board within 30 days from the date of this Decision and Order, by filing a notice of appeal with the **Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601.** A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room –2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.